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New York State Conference of Blue Cross & Blue Shield Plans, et al. v. Travelers Insurance Company, et al.: Medical Malpractice and Enabling Regulation in States Again

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COMMENT

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, ET AL. V. TRAVELERS INSURANCE COMPANY, ET AL.: Medical Malpractice and Enabling Regulation In States Again

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I. INTRODUCTION

Medical malpractice is not the most likely subject to come to mind when one thinks about the Employees Retirement Income Security Act ("ERISA").¹ However, several recently published articles have documented the relationship between ERISA and contemporary actions in the area of malpractice law.² Under ERISA, medical malpractice law has become the chess game of the nineties. Courts continually have to respond to moves and countermoves by those attempting to play the game without encountering the checkmate of malpractice law: ERISA preemption.³ Until recently, attorneys for health maintenance organiza-

1. Employees Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001-1144 (1994).

2. See, e.g., Larry J. Pittman, *ERISA's Preemption Clause and the Health Care Industry: An Abdication of Judicial Law-Creating Authority*, 46 FLA. L. REV. 355 (1994); O. Mark Zamora, *Medical Malpractice and Health Maintenance Organizations: Evolving Theories and ERISA's Impact*, 19 NOVA L. REV. 1047 (1995); Susan J. Stayn, Note, *Securing Access to Care in Health Maintenance Organizations: Toward a Uniform Model of Grievance and Appeal Procedures*, 94 COLUM. L. REV. 1674 (1994).

3. ERISA contains a broad preemption clause which reads as follows:

§ 1144. Other laws

(a) Supersedeure; effective date. Except as provided in subsection (b) of this section, the provisions of this subchapter . . . shall supersede *any and all State laws* insofar as they may now or hereafter *relate to* any [covered] employee benefit plan

(b)(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall

tions ("HMO's"), independent physician associations ("IPA's"), and preferred provider organizations ("PPO's"), have frequently shielded their respective organizations from liability for negligence by classifying all medical decisions as "benefit determinations" of an ERISA-protected employee benefit plan.⁴

The recent Supreme Court decision in *New York State Conf. of Blue Cross & Blue Shield Plans, et al. v. Travelers Ins. Co. et al.* ("*Travelers*"), however, indicates that the rules of this game may be changing.⁵ This Note will place ERISA preemption in a historical perspective and attempt to ascertain the impact of the *Travelers* decision in the area of state medical malpractice law. More importantly, this note will survey *post-Travelers* judicial opinions in an attempt to assess the existing state of ERISA preemption and to suggest strategic moves to avoid the "checkmate."

II. THE TRAVELERS DECISION

In *Travelers*, several commercial insurers, acting as fiduciaries of ERISA health plans (the "plans"), filed suit against individual authorities of the State of New York.⁶ The insurers alleged that a New York Stat-

be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

ERISA § 1144 (a), (b)(2)(A) (1994) (emphasis added).

4. See, e.g., *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1329-32 (5th Cir. 1992) (citing *Pilot Life v. Dideaux*, 481 U.S. 41, 47-48 (1987)). The court in *Corcoran* found that "[t]he principle of *Pilot Life* that ERISA preempts state law claims alleging improper handling of benefit claims is broad enough to cover the cause of action asserted here." *Corcoran*, 965 F.2d at 1332. In *Pilot Life*, the plaintiff sought compensatory and punitive damages for an allegedly improper denial of disability benefits. 481 U.S. at 43. Similarly, the plaintiff in *Corcoran* was seeking compensatory and punitive damages. However, the cause of action was not based on improper handling of benefits. Rather, it was based on negligence in the denial of benefits. The *Corcorans* alleged that the insurance company was making "medical decisions," and that it had done so negligently. While the *Corcoran* court accepted that United was making medical determinations, it felt compelled by *Pilot Life* to find that those "medical determinations" were being made as "part and parcel" of the benefit determinations, and therefore were preempted by ERISA. *Corcoran*, 965 F.2d at 1332.

5. 115 S. Ct. 1671 (1995).

6. See *Travelers Ins. Co. v. Cuomo*, 813 F. Supp. 996 (S.D.N.Y. 1993). *The plaintiffs*: Health Insurance Association of America, American Council of Life Insurance, Life Insurance Council of New York, Inc., Aetna Life Insurance Co., Aetna Health Plans of New York, Inc., Mutual of Omaha Insurance Co., The Union Labor Life Insurance Co., Professional Insurance Agents of New York, Inc. Trust, New York State Health Maintenance Organization Conference and Health Services Medical Corporation, MVP Health Plan, Wellcare of New York, Mid-Hudson Health Plan, Oxford Health Plan, Capital District Physicians Health Plan, Choicecare Long Island, Independent Health, Travelers of New York, Physicians Health Services, Preferred Care and U.S. Healthcare. *The Defendants*: Mario M. Cuomo (Governor of the State of New York), Mark Chassin, M.D. (Commissioner of Health), Salvatore R. Curiale, (Superintendent of Insurance), Mary Jo Bane (Commissioner of Social Services), Robert Abrams (Attorney General), New York

ute⁷ requiring most private insurers and HMO's, but not Blue Cross & Blue Shield (the "Blues"), to pay surcharges on hospital charges, was a state law "relating to" employee benefit plans, and therefore was prohibited by ERISA. The district court for the Southern District of New York held that the insurance regulation, though not aimed directly at them, had a significant impact on ERISA plans.⁸ The court therefore granted plaintiffs' motion for summary judgment in part and denied defendants' motion and cross-motions for summary judgment.⁹ Relying on the Supreme Court's decisions in *Shaw* and *Pilot Life*, the Court of Appeals for the Second Circuit affirmed.¹⁰ The Supreme Court granted certiorari.¹¹ Finding that the surcharges at issue did not "relate to" an employee benefit plan within the meaning of ERISA's preemption pro-

State Conference of Blue Cross & Blue Shield Plans, Empire Blue Cross and Blue Shield, and the Hospital Association of New York State.

7. See *id.* at 999 (citing N.Y. PUB. HEALTH LAW §§2807-c(1) (Consol. Supp. 1995) (repealed 1996)). The statute required that insurance carriers of patients covered by any type of health plan, with the exception of the Blues, HMO's, or government plans, pay a 13% surcharge above the established diagnosis related group ("DRG") rate. The surcharge was to be retained by the hospital to provide a fund for indigent care. The New York Omnibus Revenue Act of 1992 temporarily increased the surcharges by an additional 11% for private insurance companies. N.Y. PUB. HEALTH LAW § 2807-c (11)(i) (Consol. Supp. 1995). The statute also included a nine percent surcharge on previously exempt HMO's if they did not have a specified percentage of Medicaid-eligible enrollees in their plans. N.Y. PUB. HEALTH LAW § 2807-c (2-a)(b) (Consol. Supp. 1993). However, these surcharges were to be paid into a statewide pool.

Also at issue in *Travelers* was an Actuarial Information Letter (No. 5), which regulated how self-insured plans obtain stop-loss insurance. It provided that: (1) self-insured plans could only obtain stop-loss protection if the plan provided statutorily determined benefit packages; (2) required self-insured plans to provide beneficiaries a statutory conversion policy and (3) required self-insured plans to provide protections against plan insolvency. 813 F. Supp. at 1011-12.

8. See *id.* at 1011-12; see also *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 141 (1987).

9. See *id.* at 1012 (holding that statute's surcharge had a significant economic effect on ERISA plans and was therefore preempted). The district court reasoned that based on prior cases, the test for whether a state law preempted an ERISA plan was whether it had any effect on the costs of the plan.

10. See *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708, 711 (2d Cir. 1993); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983). *Shaw* held that ERISA's preemption clause must be read broadly to reach any state law having a connection with, or reference to, covered benefit plans. In *Pilot Life*, the Supreme court stated that the term "relate to" is to be accorded "its broad common-sense meaning." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987). "Under this 'broad common-sense meaning,' a state law may 'relate to' a benefit plan, and thereby be preempted, even if the law is not specifically designed to affect such plans or the effect is only indirect . . ." *Ingersoll-Rand Co.*, 498 U.S. at 139 (quoting *Pilot Life*, 481 U.S. at 47).

Based on these holdings, the Court of Appeals for the Second Circuit determined that the surcharges in question would increase the costs of insurance and HMO health care so as to interfere with the choices that ERISA plans would make for health care coverage by deliberately making some insurance more attractive than others. See *Travelers*, 14 F.3d at 719. Accordingly, the regulation constituted a "connection with" ERISA plans, thereby triggering preemption. *Id.* at 719-20.

11. See *New York State Conf. of Blue Cross & Blue Shield v. Travelers Ins. Co.*, 115 S. Ct. 305 (1994).

vision,¹² the Court held that the statute was not preempted.¹³

Looking at ERISA's objectives as a guide to the scope of the state law that "Congress understood would survive,"¹⁴ the Court found that the "basic thrust of the pre-emption clause . . . was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans."¹⁵ With that in mind, the Court found that ERISA preempts state laws that mandate employee benefit structures or their administration, as well as those that provide alternative enforcement administration.¹⁶ The Court in *Travelers* found that the purpose of the challenged surcharges is to make the Blues, who provide coverage to many high risk subscribers that commercial insurers normally reject,¹⁷ more attractive to plan purchasers. Therefore, the Court held that the surcharges did have an indirect economic effect on choices that insurance purchasers would make.¹⁸ However, the Court went on to explain that an *indirect economic influence* does not bind plan administrators to

12. See *infra* notes 58-63 and accompanying text.

13. See *Travelers*, 115 S. Ct. 1671, 1676-83 (1995).

14. *Id.* at 1677.

15. *Id.* at 1677-78.

16. See *id.*; see also *Shaw v. Delta Airlines*, 463 U.S. 85, 97 (1983)(ruling that "[New York's] Human Rights Law . . . and [New York's] Disability Benefits Law . . . requires employers to pay employees specific benefits . . . [and therefore] clearly 'relate[s] to' benefit plans."); *FMC v. Holliday*, 498 U.S. 52, 60 (1990) (providing that state law that prohibited plans from requiring reimbursement from beneficiary in the event of recovery from a third party 'related to' employee benefit plans as contemplated by ERISA. The costs of foregoing reimbursements would depend on the state in which the plan was located, and therefore would not result in "uniform legislation.").

17. The Blues have traditionally maintained an "open-enrollment" policy. See GEORGE A. ANNAS ET AL., *AMERICAN HEALTH LAW* 17-22 (1990). This open-enrollment policy, combined with a "community rating" charge, has increasingly put the Blues at a disadvantage in the insurance marketplace. Under an open-enrollment policy, anyone who cares to purchase insurance will be accepted. See *id.* A community rating scheme provides that the premiums charged will be uniform for the entire community of subscribers. See *id.* When these two factors are combined, the result is an enrollment community made up of a non-risk-selected population. See *id.* Logically, a non-risk-selected population will consist of a greater proportion of higher risk participants. See *id.* Because the Blues charge all participants the same premium based on community experience, the community rating costs are higher for all participants, which, in turn, makes the Blues premiums higher than those for commercial insurers. See *id.* This problem is exacerbated by the fact that employed people statistically are healthier than unemployed people, which means that providing employee insurance is traditionally less expensive. See *id.* In addition, the majority of insured people are employed and obtain their insurance through employee benefit plans. So the Blues take everyone, but have higher rates than commercial insurers. Unemployed persons, who are traditionally at higher risk, and employed persons to whom medical benefits are not available, will most likely not be able to afford the higher premiums offered by the Blues. See *id.* Although the Blues now have a risk selection option which offers lower premiums, they still have their traditional open-enrollment, community rating scheme.

18. See *Travelers*, 115 S. Ct. at 1678-79.

any particular choice of providers.¹⁹ It does not preclude uniformity in administrative practices.²⁰ Nor does it preclude the provision of a uniform interstate benefit package.²¹ Rather, the Court held that the indirect economic influence "simply bears on the costs of benefits and the relative costs of competing insurance to provide them."²²

Understanding this portion of the Court's opinion is crucial to determining the impact that *Travelers* may have on a plaintiff's ability to avoid ERISA preemption and successfully keep tort actions against prospective review decisionmakers in state courts.²³ In particular, the Court reasoned that "cost-uniformity almost certainly is not an object of pre-emption."²⁴ Rate differentials are common even in the absence of state action, and therefore the Court found it unlikely that ERISA meant to bar such indirect influences under state law. The Court offered "quality control standards" as an example of a traditional area of state regulation that could impose indirect economic cost on a state plan.²⁵ Further, the

19. *See id.* at 1679.

20. *See id.*

21. *See id.*

22. *Id.* In fact, the Court stated that "[c]harge differentials for commercial insurers, even prior to state regulation, 'varied dramatically across regions.'" *Id.* (citation omitted). More importantly, however, was the Court's statement that "the existence of other common state action with indirect economic effects on a plan's costs leaves the intent to pre-empt even less likely." *Id.* "Indeed, to read the pre-emption provision as displacing *all state laws* affecting costs and charges on the theory that they indirectly relate to ERISA . . . could not be squared with [the Court's prior announcements]." *Id.* at 1679-80 (emphasis added).

23. This requires an understanding of the relationship between malpractice and ERISA, along with the complications that prospective utilization review has added to the field. *See infra* notes 47-51.

24. *Travelers*, 115 S. Ct. at 1680. The Court stated that "laws with only an indirect economic effect on the relative costs of various health insurance packages in a given State are a far cry from those 'conflicting directives' from which Congress meant to insulate ERISA plans." *Id.* *See also* *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990); 120 CONG. REC. 29,933 (1974) (statement of Sen. Williams) ("With the narrow exceptions specified in the bill, the substantive and enforcement provisions . . . are intended to pre-empt the field for Federal regulations, thus eliminating the threat of conflicting or *inconsistent* State and local regulation of employee benefit plans.").

25. Malpractice liability is the traditional mechanism for assuring quality health care delivery. *See ANNAS, supra* note 17 at 399-415. Although arguably ineffective, it still is the predominate method of assuring quality. *See id.*; *see also* Pittman, *supra* note 2 at 422-30 (arguing that tort law is necessary to ensure accountability in medical decision-making). Professor Pittman proposes that state medical malpractice lawsuits against the doctors and nurses who actually make the prospective utilization review decisions are supported by ERISA's purpose of protecting employees. *See id.* at 436-42. He proposes that the courts carefully scrutinize a defendant's use of an affirmative defense consisting of ERISA preemption. *See id.* at 441. He would suggest requiring the defendant insurance plan to prove, by a preponderance of the evidence, "that the application of a state's medical malpractice laws and lawsuits would create such administrative inefficiencies that the benefit plan would have to conduct its prospective utilization review functions differently in different states," so as to preclude uniformity in regulation from state to state. *Id.* at 420. In the alternative, Professor Pittman suggests that, should the court fail to find that such malpractice actions are not "too tenuous, remote or peripheral," so as to escape

Court went on to say that the "mandates for rate differentials would not be pre-empted unless other regulation with indirect effects on plan costs would be superseded as well."²⁶ The Court did not address the question of whether the surcharges could be applied to self-insured funds, but instead left it to the court of appeals to consider on remand.²⁷ On remand, the Court of Appeals for the Second Circuit held that the surcharges could be imposed on self-insured plans as well.²⁸ So the applicability of the *Travelers* opinion should extend to self-insured plans as well.²⁹

This decision is remarkable for several reasons. The first is that it narrowed the test for determining whether a state law "relates to" an ERISA plan so as to trigger preemption.³⁰ The second significant aspect is that a unanimous court rejected the principle that any law that imposes costs upon an employee benefit plan is presumptively preempted unless saved by ERISA's insurance savings clause, thereby allowing states to participate in active health care reform.³¹ However, the most remarka-

preemption, then they should use the power that ERISA has given them to create a federal common law. *Id.* at 441-42. *See also* Zamora, *supra* note 2.

26. *Travelers*, 115 S. Ct. at 1679 (indicating that the more traditional state regulations that the proposed interpretation of ERISA's preemption clause would preclude, the less likely that Congress meant to preempt that particular area of traditional state authority). *But see* FMC v. Holliday, 498 U.S. 52, 60 (1990) (stating that Pennsylvania's anti-subrogation law, while a traditional state law, was preempted as the relationship to employee benefit plans was not "too tenuous, remote or peripheral"). However, in *FMC* the ability of a company to subrogate to a participant's claim in one state and not in another could make the plan more expensive to administer in one state over another, and could require inconsistent procedures for claims processing between states. *See id.*

27. *See* 115 S. Ct. at 1675, n.4.

28. *See Travelers Ins. v. Pataki*, 63 F.3d 89 (2d Cir. 1995). On remand, the court of appeals found that the only time a plan's self-insured status matters is when ERISA is found to preempt a state law. If the state law is preempted, then the applicability of the "savings clause" is determined. *See id.* at 93; *see also* 29 U.S.C. § 1144(b)(2)(A) (1994). Under the savings clause, a law that is otherwise found to "relate to" an employee benefits plan may be excepted if it is a law that purports to regulate insurance. Then and only then will the character of the plan come into play. The "deemer clause" provides that a self-insured employee benefit plan may not be "deemed to be an insurance company or other insurer." 29 U.S.C. § 1144(b)(2)(B) (1994). Since the Supreme Court had determined that the law at issue was not a law that "related to" an employee benefit plan so as to trigger preemption, the insurance savings clause and the deemer clause were inapplicable. *See Travelers*, 63 F.3d at 93.

29. This presents what could be an interesting problem down the line. Many self-insured plans hire an insurance company to administer their plans. In making benefit decisions, the insurance company will perform prospective review. If the plan brings a negligence claim against the insurance company, it can be held liable to the plan. If the insurance company does not live up to the applicable standard of care, the question remains whether a participant can bring a malpractice suit against it.

30. *See Travelers*, 115 S. Ct. at 1680 (stating that if a state law produces merely an indirect economic effect upon an ERISA plan, but does not force the ERISA plan's choice of coverage, then it does not "relate to" the plan as envisioned by Congress, and therefore is not preempted).

31. "[N]othing in the language of the Act or the context of its passage indicates that Congress

ble aspect of the decision is the Court's dicta indicating that the area of quality control is an inherent state power that would not be preempted were the issue to be presented to the Court.³²

This Note's proposition is that the Court could have defeated preemption down another path. Therefore, this Note will first provide an analysis of the caselaw leading to the *Travelers* decision and the arguments that have either defeated or succumbed to ERISA preemption. Next, this Note will survey some of the lower federal courts' post-*Travelers* decisions in an attempt to ascertain what weight they have given to this dicta. Finally, using the post-*Travelers* decisions as a guidepost, this Note will make practical suggestions to avoid ERISA preemption defenses in actions against health plans.

III. HISTORICAL PERSPECTIVE

A. *Traditional Notions of Medical Malpractice*

Ordinarily a patient who was damaged in some manner by a physician's negligence files suit in a state court asking for compensatory, and if warranted, punitive damages. The plaintiff then has to establish that: (1) the doctor owed a duty of reasonable care to the plaintiff; (2) the doctor has breached this duty; (3) the breach was both the proximate cause and the cause in fact of the plaintiff's injury; and finally (4) the patient has suffered actual damages.³³

State courts have traditionally been the exclusive forum for medical malpractice actions between persons of the same state.³⁴ If a party in a federal court had a federal claim that was "substantial," then the court could, in its discretion, hear a state law claim that accompanied the federal claim.³⁵ However, after Congress enacted ERISA in 1974, this clear jurisdictional line became obfuscated.³⁶ Courts began reading

chose to displace general health care regulation, which historically has been a matter of local concern." *Id.* at 1680-81.

32. See *id.* at 1679-80.

33. See RESTATEMENT (SECOND) OF TORTS (1987).

34. See U.S. CONST. amend. X (providing that "[t]he powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people"); U.S. CONST. Art. III, § 2. (providing jurisdiction for federal courts of the United States).

35. Provided that the state and federal claims had a common nucleus of operative facts, the state claim would be heard. This was originally accomplished through the doctrine of pendant jurisdiction. See 28 U.S.C. § 1367 (1995).

36. See *Pilot Life Ins. Co. v. Dideaux*, 481 U.S. 41, 47 (1987); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985); *Shaw v. Delta Airlines* 463 U.S. 85, 96-97 (1983) (all holding that the phrase "relates to" is to be given its broad common sense meaning, such that a state law "relates to" an employee benefit plan in the normal sense of the phrase. In other words, the law has a connection with or a reference to such a plan).

ERISA's preemption provision very broadly so as to preclude a variety of state law claims. Breach of contract, intentional infliction of emotional distress and malpractice are just a few of the causes of action that were prohibited.³⁷ Preemption is a question governed by the Supremacy Clause of the Constitution.³⁸ That federal preemption might leave a party without a remedy troubled the court in *Corcoran*, especially in the area of prospective utilization review, but the Court felt that ERISA's express preemption provision mandated a finding that extra-contractual damages (i.e. pain, suffering and emotional distress) were not remedies they could award.³⁹

B. *Traditional Notions Expanded*

As medical delivery has changed over the years, states have adapted with the development of additional causes of action in the medical malpractice arena.⁴⁰ Through concepts of vicarious liability, corporate liability, and enterprise liability, states have allowed plaintiffs to recover from health care centers for the negligence of employed physi-

37. See *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1338 (5th Cir. 1992) (holding that ERISA preempts tort claim for emotional distress damages). The court reasoned that a prospective review decision to deny authorization for in-patient hospital stay was not a "medical decision," but rather was a "benefit determination." *Id.* In order to determine negligence in the denial of benefits, the court would have to look at the plan and evaluate whether what was promised was received. See *id.* The Court of Appeals for the Fifth Circuit determined that the tort claim was therefore preempted by ERISA. See also *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 62-63 (1987) (finding common law contract and tort claims arising from termination of benefits generally applicable state claims, but preempted by ERISA).

38. U.S. CONST. art. VI, cl.2:

This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

39. See *Corcoran*, 965 F.2d at 1338. The court went on at length about how their decision troubled them. The court recognized that its decision "eliminates an important check on the thousands of medical decisions routinely made in the burgeoning utilization review system." *Id.* The court also recognized that making liability rules inapplicable would result in "less deterrence of substandard medical decision-making." *Id.* The court even recognized that the cost of paying for malpractice judgments is not necessarily above the normal cost of doing business in the insurance field. See *id.* However, the Court felt that because cost containment features did not exist at the time ERISA was implemented, any changes in preemption should be affected by Congressional action to prevent judicial overstepping. See *id.* The court also stated that "the lack of an ERISA remedy does not affect a pre-emption analysis." *Id.* at 1333; see also *Shaw*, 463 U.S. at 96-97; *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236, 248 (5th Cir. 1990) (both holding that state laws "relate to" employee benefit plans broadly whenever they have "a connection with or reference to such a plan").

40. See *Zamora*, *supra* note 2 at 1053. Mr. Zamora provides an analysis of vicarious and direct corporate liability in the HMO context.

cians.⁴¹ A major principle behind allowing these causes of action is that, with the increasing numbers of group-providers such as HMO's, PPO's and IPA's, medical decisionmaking is no longer solely in the realm of the personal physician.⁴² Additionally, where these medical delivery systems are utilized, a patient's choice of a practitioner is often limited to a specified group of approved physicians, thereby justifying holding those health plans liable for negligence in their hiring and supervisory practices.⁴³ However, as the states have expanded the traditional notions of medical malpractice so as to encompass these modern health care delivery systems, preemption problems have increased.⁴⁴

C. *The Concept of ERISA Preemption*

An understanding of the decisions interpreting ERISA's preemption clause is crucial to an understanding of the potential impact that the *Traveler's* decision may have in the area of vicarious liability and the ability of states to reclaim tort law. This section will focus on the purpose behind enacting, and the damages that may be recovered, under ERISA.

Congress enacted ERISA in 1974⁴⁵ to protect employees' expectations in pension funds and benefit plans.⁴⁶ In order to do this, ERISA

41. See *id.* at 1052. Usually, this is accomplished through the theory of ostensible agency.

42. This arises from a combination of factors. First, an HMO may offer a physician incentives for reducing the number of tests ordered and procedures performed. Second, an HMO can refuse pre-authorization for particular procedures. A physician will then inform the patient of the denial of benefits decision. The patient must then choose whether or not to undergo the procedure. If the patient decides to forego the procedure, and an adverse reaction occurs, who really made the decision? See generally ANNAS, *supra* note 17.

43. See *Boyd v. Albert Einstein Med. Ctr.*, 547 A.2d 1229 (Pa. Super. Ct. 1988). In *Boyd*, the appellate court found that certain HMO's are "total health care systems." As such, the physicians that they hire are "ostensible agents." The key to finding an ostensible agency is whether "the patient is (reasonably) 'looking to' the HMO rather than the individual doctor as the provider of care, and whether the HMO has 'held out' the physician as its employee or agent." *Id.* at 1232-34; ANNAS, *supra* note 17 at 286; see also Zamora *supra* note 2 at 1050.

44. See discussion *supra* note 42.

45. See 29 U.S.C. §§ 1001-1144 (1994).

46. At the time ERISA was enacted, there was a prevalence of employers underfunding their pension plans. Employees were not receiving the benefits that they had been promised and relying on. Congress provided that ERISA is meant to:

protect . . . participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

29 U.S.C. § 1001(b) (emphasis added).

contains strict requirements for funding,⁴⁷ disclosure,⁴⁸ and fiduciary duty,⁴⁹ that every plan must conform with.⁵⁰ Congress enacted ERISA's preemption provision to assure plans a uniform set of regulations and to prevent inconsistent regulation on plans from state to state.⁵¹

This is the rook of the chess game (i.e., the piece that blindsides you). Standing in the path without a pawn to protect them, plaintiffs will fall helplessly to the checkmate of ERISA's preemption clause. The trouble is that interpretations of the "relate to" language had eliminated far too many pawns, leaving plaintiffs increasingly exposed to checkmate. Since ERISA was meant to supersede state law, Congress provided a specific civil enforcement scheme to provide relief to plan beneficiaries in the event that ERISA's requirements were violated.⁵² It is not possible to discuss the confusion inherent in the "relates to" language without addressing the civil enforcement scheme contemporaneously.⁵³

In 1983, the Supreme Court held that ERISA's preemption language should be read in light of Congress's intent at the time that ERISA was enacted.⁵⁴ In *Shaw v. Delta Airlines*, the Court explained that Congress had deliberately eliminated a proposed preemption clause that was limited to specified subjects covered by ERISA.⁵⁵ Instead, the Conference Committee removed the limiting language and indicated that the "section's pre-emptive scope was as broad as its language."⁵⁶ The purpose behind the elimination was to ensure that ERISA plans would be free of the threat of conflicting or inconsistent state and local regula-

47. See 29 U.S.C. § 1102(b)(1) (establishment of plan); §§ 1081-85 (funding requirements).

48. See 29 U.S.C. § 1102(a)(1) (writing requirement); §§ 1022-25 (specifics of writing requirements).

49. See 29 U.S.C. § 1102(a), (c).

50. See 29 U.S.C. § 1003. ERISA applies to every plan if "established or maintained" by an employer, employee organization or both, engaged in any industry or activity affecting commerce. *Id.* However, Government, church and excess benefit plans are exempt, as are plans set up to comply with workmen's compensation, unemployment or disability insurance laws. See 29 U.S.C. § 1003(b).

51. The preemption clause reads, in pertinent part that "this chapter shall supersede *any and all state laws* insofar as they may now or hereafter *relate to* any employee benefit plan . . ." 29 U.S.C. § 1144(a) (1994) (preemption clause) (emphasis added).

52. See 29 U.S.C. § 1132. Pertinent to this discussion is § 1132 (a)(2), which allows plan beneficiaries to sue under ERISA for benefits due under the plan and to enforce or declare future rights under the terms of the plan. The phrase "to sue for benefits due him under the terms of the plan" is the second piece to the preemption problem.

53. All too often in court opinions, the damages that plaintiffs were seeking were interpreted to be claims under §1132(a). In other words, an injured beneficiary sues for pain and suffering. The court interprets that as seeking "benefits due him under the terms of the plan."

54. See *Shaw v. Delta Airlines*, 463 U.S. 85, 97-99 (1983).

55. See *id.* at 98 (citing H.R. REP. NO. 93-1280, at 383 (1974)).

56. H.R. REP. NO. 1280.

tion of employee benefit plans.⁵⁷ Accordingly, the Court found that it was compelled to read "relate to" in the broad common sense meaning.⁵⁸ In 1987, the Court maintained its position that "relates to" must be read broadly to reach any state law having a connection with, or reference to, covered employee benefit plans.⁵⁹ However, in 1987, the Court held that, even if a claim "relates to" an employee benefit plan, it may be saved by ERISA's insurance savings clause.⁶⁰

In summary, the Supreme Court has held that a state law that directly requires employers to offer certain medical benefits "relates to" employee benefit plans as contemplated by ERISA, but is saved from preemption as a law regulating insurance.⁶¹ The Court has also held that a state law that has an indirect effect upon an employee benefit plan is preempted unless the relationship is too tenuous, remote or peripheral to the plan to justify preemption.⁶² However, until the *Traveler's* decision, the Court had not defined what type of law might be considered too tenuous, remote or peripheral to escape liability. The Court has also indicated that traditional state laws of general application may not be subject to preemption.⁶³ This is the crux of this Note.⁶⁴ Is a state law claim for emotional distress, wrongful death, or pain and suffering a claim with a relationship to an employee benefit plan that is too tenuous, remote and peripheral to the plan to be preempted?⁶⁵

57. See *Shaw*, 463 U.S. at 99-100 n.20.

58. "A state law relate[s] to a benefit plan in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Id.* at 96-97. *Accord* *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985).

59. See *Pilot Life Ins. Co. v. Dideaux*, 481 U.S. 41, 47-48 (1987). The Court's interpretation of "relates to" has been anything but unwavering. See, e.g., *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 830-32 & n.6 (1988) (holding that garnishment action does not "relate to" ERISA plan because it is a law of general applicability).

60. See *Pilot Life*, 481 U.S. at 48-49. *Pilot Life* broadened the "relates to" language even further than *Shaw* had. *Id.* The Court's language in *Pilot Life* indicated that any state law claim that could in any way "relate to" an ERISA employee benefit plan would be preempted unless saved by ERISA's insurance savings clause. See 29 U.S.C. § 1144(b)(2)(A) ("[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.") ("insurance savings clause"). See also *Metropolitan Life*, 471 U.S. at 739-47 (defining "regulating insurance" as contemplated by ERISA).

61. See *Metropolitan Life*, 471 U.S. at 758.

62. See *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 130 & n.1 (1992).

63. See *Travelers Ins. Co. v. New York Conf. of Blue Cross and Blue Shield Plans*, 115 S. Ct. 1671, 1683 (1995); see also *Mackey*, 486 U.S. at 831-32.

64. While the *Travelers* decision is extremely important to other areas of preemption analysis, this Note's focus is limited to the area of preemption of state law quality control standards, i.e. negligence of third party prospective utilization review decisions.

65. See Pittman, *supra* note 2. Professor Pittman's article argues that these traditional state law claims should not be pre-empted by ERISA. He believes that the Court has abdicated its rulemaking authority. Professor Pittman thinks that, if the courts refuse to stop finding complete preemption of such state law causes of action, they should use the power given to them in ERISA

Before one can understand the impact that the *Travelers* decision may have, it is necessary to assess the pre-*Travelers* status of ERISA preemption in the area of state malpractice law, particularly in the area of vicarious liability. As the states have expanded the traditional notions of medical malpractice to encompass modern health care delivery systems, preemption problems have increased.⁶⁶

The typical scenario in the chess game of ERISA preemption is as follows. A patient sees a physician. The physician recommends an expensive procedure (or doesn't recommend it, as the case may be one of incentives for decreased utilization of services).⁶⁷ The insurance company prospectively denies payment for the procedure.⁶⁸ The patient then chooses to forego the procedure for economic reasons,⁶⁹ or accepts the offered, and usually less expensive, alternative treatment that the health plan authorizes.⁷⁰ The patient subsequently suffers some adverse occurrence that the originally recommended treatment might have prevented.⁷¹ The patient then wants to recover for the damages that she incurred as a result of having to forego the recommended treatment.⁷² The problem is, who does the patient recover from? If the physician was negligent in discharging the patient, he may be liable.⁷³ However, if it is determined that the physician followed an appropriate standard of care,

to create federal common law causes of action to fill the gap and ensure the continuance of accountability in the delivery of health care. *See id.* at 440-42.

66. *See generally supra* note 2; *see also* John O. Blum, *An Analysis of Legal Liability in Health Care Utilization Review and Case Management*, 26 Hous. L. Rev. 191, 192 (1989); Barry R. Furrow, *Medical Malpractice and Cost Containment: Tightening the Screws*, 36 CASE W. RES. L. REV. 985, 986-87 (1986); Rodd Zolkos, *Evolution of Managed Care: Professional Liability Issues Grow as Health Care Changes*, Bus. Ins., Nov. 27, 1995, at 3.

67. *See Pittman supra* note 2 at 361-75 (presenting description of the different incentives that health plans offer physicians to achieve ultimate levels of cost containment).

68. *See id.*

69. *See Wilson v. Blue Cross of So. Cal.*, 271 Cal. Rptr. 876 (Cal. Ct. App. 1990) (patient leaves hospital earlier than recommended due to denial of authorization for further stay; ERISA not implicated).

70. *See Corcoran v. United Health Care, Inc.*, 965 F.3d 1321, 1322-24 (5th Cir. 1992).

71. *See id.* at 1324.

72. *See id.*

73. *See Wickline v. State of Cal.*, 239 Cal. Rptr. 810 (Cal. Ct. App. 1986). In *Wickline*, the patient needed leg surgery. Due to various factors, the physician determined that the patient should remain in the hospital for eight additional post-operative days. However, the insurance company declined prospective authorization and would only approve four days of additional hospitalization. The physician then discharged the patient. Subsequent to the discharge, she suffered blood clots that required amputation of her leg. The court determined that if the physician's decision to discharge had been negligent, then he could be held liable. In other words, if the normal standard of care for a similar physician would dictate the continuing hospitalization of the patient, and the physician had discharged anyway, then he could be held liable on a negligence theory. *See id.* at 817-18. *Wickline* was not an ERISA case, but it clearly illustrates the complications that third party utilization review may present to the patient attempting to pinpoint accountability for negligent injury.

he most likely will not be found liable.⁷⁴

If the physician has not been negligent,⁷⁵ who else can the patient recover from? There is no cut and dry answer. It all depends on what exactly the plaintiff is asking for. Because of *Corcoran*,⁷⁶ and because of the way that other courts have followed its lead,⁷⁷ it is extremely difficult to bring a malpractice suit against a health plan, even where the health plan's prospective review process causes a patient to forego some treatment that could have prevented injury.⁷⁸ If the health plan is an HMO, then the patient stands a better chance of recovery.⁷⁹ However, several courts have held that if the health plan is not an HMO,⁸⁰ or is an HMO that does not directly deliver health services,⁸¹ any suit against it

74. See *id.* The court went on to find that the physician in *Wickline* had not deviated from the acceptable standard of care in deciding to discharge the patient, and therefore he was not liable for damages. *Id.* at 819. This raises an interesting problem that is a corollary to the ERISA preemption problem with regard to physician decisionmaking in light of third party prospective utilization review. The issue is, when a physician has to obtain pre-approval for treatment, and that treatment is not authorized by the applicable health plan, who bears the risk that the patient will suffer some harm? In this emerging era of prospective utilization review, physicians are making medical decisions that are not always determined by the best interest of the patient. The predominance of health plans such as HMO's and PPO's has created a new picture of the doctor-patient relationship, in which the decisions for medical treatment are dictated by a third party rather than by either the physician or the patient. See Randall, *supra* note 2 at 18-19 (describing the problems created by introducing a third party reviewer into the doctor-patient relationship).

75. See *id.* at 41-43. Professor Randall presents the difficulties a patient has to overcome in an ordinary negligence suit against physicians because physicians set the appropriate standard of care, and have the expertise, knowledge, and power to do so. Professor Randall describes the complexities that introducing a third party prospective reviewer adds to the already disadvantaged plaintiff. See *id.*

76. 965 F.2d 1321.

77. See, e.g., *Dalton v. Empire Blue Cross & Blue Shield Healthnet*, 626 N.Y.S.2d 362, 364 (N.Y. 1995) ("Even the absence of remedy will n[o]t [sic] prevent the application of the ERISA preemption clause in appropriate circumstances.") (citing *Corcoran*, 465 F.2d at 1333). In *Dalton*, the court found ERISA to preclude a negligent selection cause of action against a health plan because to determine whether there was negligence would require looking at the terms of the plan and the reasons for denial). *Id.* at 364-65; see also *Nealy v. United States Healthcare HMO*, 844 F. Supp. 966, 973-75 (S.D.N.Y. 1994); *DeArmas v. Av-Med, Inc.* 814 F. Supp. 1103, 1107 (S.D. Fla. 1993).

78. If the plan is a true HMO, which participates in the actual delivery of health care services, then the odds of obtaining relief are higher. See *Butler v. Wu*, 853 F. Supp. 125, 129 (D.N.J. 1994) (stating that "[w]e concur with the reasoning adopted by . . . courts . . . who have concluded that ERISA preempts state law tort claims brought against an HMO for the negligence of one of its participating physicians, where the HMO does not itself provide health care services."). See also *Kuhl v. Lincoln Nat'l Health Plan of Kan. City, Inc.*, 999 F.2d 298, 302-05 (8th Cir. 1993); *Nealy*, 844 F. Supp. at 975. Cf. *Elsesser v. Hospital of the Phila. C. of Osteopathic Med., Parkview Div.*, 802 F. Supp. 1286, 1290-92 (E.D. Pa. 1992) (holding that claims against HMO under ostensible agency theory not preempted, even where HMO did not directly provide medical care); *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983 (E.D. Pa. 1990).

79. See *Boyd v. Albert Einstein Med. Ctr.*, 547 A.2d 1229, 1232-34 (Pa. Super. Ct. 1988).

80. See, e.g., *Corcoran*, 965 F.2d 1321 (1992).

81. See, e.g., *Altieri v. Cigna Dental Health, Inc.*, 753 F. Supp. 61, 63-64 (D. Conn. 1990).

for recovery of damages is a suit that "relates to" the health plan and the administration of the health plan, and as such, is preempted by ERISA.⁸² Perhaps even more disturbing is that the patient cannot obtain extra-contractual damages even if she sues under ERISA.⁸³ Most disturbing of all is the procedural device of "complete preemption" that defendants are using in order to render a plaintiff helpless to checkmate.⁸⁴ According to *Metropolitan Life*, any claim that is in any way an attempt to "recover benefits" under the terms of an employee benefit plan is not only preempted by ERISA, but is removable to federal court regardless of whether the plaintiff pleads the "recovery of benefits."⁸⁵ This broad reading of ERISA's preemption provision borders on the absurd.⁸⁶ If followed to its logical conclusion, any transaction that occurs between a patient and a physician could be found to be related to the existence of a health plan.⁸⁷ Theoretically, this type of interpretation could even bar suits for direct negligence against a physician. The doctor could simply claim that the relationship between him and the patient only existed because of ERISA, and therefore, any state law claim against him is preempted.⁸⁸ In addition, to read the Court's recognition of an exception

82. *Id.*; see also *Corcoran*, 965 F.2d at 1330; *Butler*, 853 F. Supp. at 129.

83. See *Comer v. Kaiser Found. Health Plan*, 45 F.3d 435, 438-39 (9th Cir. 1994); *Harsch v. Eisenberg*, 956 F.2d 651 (7th Cir. 1992).

84. See *infra* note 85 and accompanying text.

85. 481 U.S. 58, 63-65 (1987). This runs contrary to the "well-pleaded complaint" rule as set forth in *Louisville and Nashville R.R. Co. v. Mottley*, 211 U.S. 149 (1908). If the plaintiff does not plead a federal question as the basis of subject matter jurisdiction, then an anticipated defense under a federal statute will not confer subject matter jurisdiction upon the federal court. See *id.* at 153-54. Under the well-pleaded complaint rule, a defendant may not remove a claim from state to federal court if the plaintiff has not pled the federal question in his complaint. See *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 463 U.S. 1, 9-12 (1983). The plaintiff has the choice of forum, and, as a federal defense to a plaintiff's state law cause of action does not ordinarily appear on the face of his complaint, there usually is not justification for removal to federal court. See *Gully v. First Nat'l Bank*, 299 U.S. 109, 115-18 (1936). This is especially true because ERISA provides for concurrent jurisdiction between state and federal courts for plaintiffs wishing to recover benefits due them, to determine their rights to future benefits, or to enforce their rights under the terms of the plan. See 29 U.S.C. § 1144(a). Preemption is insufficient to justify removal to federal court. See *Caterpillar, Inc. v. Williams*, 482 U.S. 386, 398 (1987). The only exception to the well-pleaded complaint rule that the Supreme Court has recognized is where there is complete preemption. See *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63-64 (1987) (holding that "Congress may so completely pre-empt a particular area that any civil complaint raising this select group of claims is necessarily federal in character"). The complete preemption doctrine applies when the force of the federal statutory provision is so powerful as to displace entirely any state cause of action addressed by the federal statute. Any suit of this nature is purely a creature of federal law. See *id.* at 64 (citation omitted). The Court has determined that Congress intended complete preemption to apply to any state law cause of action that fits within the scope of ERISA's civil enforcement provisions. See *Pilot Life v. Dideaux*, 481 U.S. 41, 66 n.2 (1987).

86. See generally *Pittman supra* note 2.

87. See *id.*

88. This interpretation merely carries through the logic presented in decisions such as *Corcoran* and *Butler*. If it were not for the employee plan, the employee would never have gone

to the well-pleaded complaint rule to extend to every possible state law that may be preempted by ERISA, would make Congress' grant of concurrent jurisdiction superfluous.⁸⁹ This is not the result that ERISA was intended to bring about. The Court's decision in *Travelers* seems to recognize the potential absurdity of this reading.⁹⁰

D. *Impact of Travelers on Preemption*

As mentioned above, until recently, the outlook for recovery by our hypothetical patient did not look promising.⁹¹ However, in February of 1995, the Supreme Court may have opened the door for states to reclaim quality control mechanisms over the delivery of medical services.⁹² In *Travelers*, the Court pulled back from what had been an ever increasingly broad reading of ERISA's preemption provision.⁹³ Before *Travelers*, the Court had expansively interpreted ERISA to preempt any state law claim which makes reference to or relates to any employee benefit plan.⁹⁴ Accordingly, the lower courts found an increasing number of state laws preempted.⁹⁵ Among the "laws to go" were intentional infliction of emotional distress and wrongful death.⁹⁶

Although the Court did not specifically say that medical malpractice actions are not preempted by ERISA, it would certainly be a justified decision for a lower court to make.⁹⁷ This next section will analyze

to the specific doctor. Therefore, any complaint about anything arising out of the relationship relates to the employee plan.

89. See 29 U.S.C. § 1144(e) (1994), which reads:

Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 1021(f)(1) of this title. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

90. See *Travelers Ins. Co. v. New York Conf. of Blue Cross and Blue Shield Plans*, 115 S. Ct. 1671, 1683 (1995).

91. See *supra* note 78 and accompanying text; see also *Butler v. Wu*, 853 F. Supp. 125, 130-31 (D.N.J. 1994) (holding that ERISA preempts malpractice action against health plan where participant in plan alleged that plan negligently selected treating physician and hospital); *Altieri v. Cigna Dental Health*, 753 F. Supp. 61 (D. Conn. 1990) (holding that ERISA preempts claim where central feature of participant's claims were circumstances of participant's treatment under employer's medical plan); *Rollo v. MaxiCare*, 695 F. Supp. 245 (E.D. La. 1988).

92. See *Travelers*, 115 S. Ct. at 1682.

93. See 29 U.S.C. at § 1144(a).

94. See discussion *supra* notes 58-63.

95. See *Pilot Life v. Dideaux*, 481 U.S. 41, 47-48 (1987) (preempting common law causes of action seeking damages for improper processing of claim for benefits); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 95-100 (1983) (preempting state insurance anti-discrimination law).

96. See *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1338-39 (5th Cir. 1992).

97. "[N]othing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local

some of the cases decided subsequent to the *Travelers* decision, and will attempt to predict what types of claims might be allowed.

In dicta, the *Travelers* decision indicated that state law claims for malpractice against third party prospective review systems either directly or via vicarious liability might not be preempted by ERISA.⁹⁸ The fact that the *Corcoran* case was decided two years before *Travelers* provides hope that courts will now reconsider their "relates to" analysis. The Court in *Travelers* also seemed to go to great lengths to address the area of "traditional state law," rather than deciding that the New York law was a law "regulating insurance." The Court also specifically mentioned quality control as being an area of traditionally local concern.⁹⁹ Most interesting is that the Court could have found that the surcharges did "relate to" employee benefit plans so as to trigger preemption,¹⁰⁰ but did not.¹⁰¹

The situation would be much clearer were it not for the *Corcoran* case.¹⁰² The *Corcoran* court held that a Louisiana state law, allowing a claim for wrongful death by alleging that a third party provider of utilization review services had failed to live up to the applicable standard of care, was preempted by ERISA.¹⁰³ The court also held that ERISA did not authorize damages for emotional distress in a claim for wrongful denial of benefits.¹⁰⁴ The Corcorans appealed this decision, and the Supreme Court denied the writ of certiorari.¹⁰⁵ While the denial of certiorari indicates neither approval nor disapproval for the *Corcoran* deci-

concern." *Travelers*, 115 S. Ct. at 1680. See *Hillsborough County v. Automated Med. Lab., Inc.*, 471 U.S. 707, 719 (1985); B. FURROW, ET AL., *HEALTH LAW* §§ 1-6, 1-23 (1995); see also *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988) (holding that state general garnishment law would impose indirect administrative costs, and even might prevent plan participants from receiving their benefits, but that as a law operating only as an indirect source of merely economic influence on administrative decisions it should not suffice to trigger preemption).

98. See *supra* notes 22-31.

99. See *Travelers*, 115 S.Ct. at 1680. See *supra* text accompanying notes 22-31.

100. See, e.g., *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 758 (1985) (holding that a state mandating coverage of specified minimum mental healthcare benefits by insurers did directly affect ERISA plans, but were saved from preemption by the insurance savings clause). The Court in *Travelers* could have easily found that *Metropolitan Life* supported a finding that the proposed surcharges "related to" employee benefit plans, and could have proceeded to save the surcharges through the insurance savings clause. Instead, the Court decided to follow the line of reasoning in *Mackey* to find that Congress did not intend to forbid the use of traditional state law enforcement mechanisms. See *Mackey*, 486 U.S. at 831-32.

101. See *Travelers*, 115 S.Ct. at 1683.

102. 965 F.2d 1321 (5th Cir. 1992).

103. *Id.* at 1339.

104. See *id.*

105. See *Corcoran v. United Healthcare*, 113 S. Ct. 812 (1992).

sion, it is interesting that the Supreme Court chose the language that it did in handing down the *Travelers* decision.

More recently, the Court of Appeals for the Third Circuit, in *Dukes v. U.S. Healthcare, Inc.*, decided that a plaintiff's claim against an HMO for malpractice was not preempted by ERISA.¹⁰⁶ In *Dukes*, the wife of an HMO participant brought suit in state court alleging medical malpractice and other negligence against the HMO, among others. In her complaint, she alleged that the HMO was responsible, under Pennsylvania's state ostensible agency law, for the negligence of the various doctors and other medical service providers.¹⁰⁷ She further alleged that the HMO had failed to exercise reasonable care in its selection, retention, screening, monitoring and evaluation of the personnel who actually provided medical services under a theory of direct negligence.¹⁰⁸ In the companion case that was decided in *Duke*,¹⁰⁹ the plaintiff brought suit in state court alleging negligence of the HMO via vicarious liability under an ostensible and actual agency theory.¹¹⁰ They also sued the HMO under a theory of direct negligence.¹¹¹

Here, however, the game changed. As usual, the defendant HMO's in *Dukes*¹¹² removed the case to federal court, claiming "complete preemption" under the *Metropolitan Life* exception to the well-pleaded complaint rule.¹¹³ The district court held that the the plaintiff's claims "related to" an ERISA plan, and therefore were preempted because "any ostensible agency claim must be made on the basis of what the benefit plan provides and is therefore 'related' to it" and "the treatment received must be measured against the benefit plan and is therefore also 'related' to it."¹¹⁴ The district court dismissed both claims. Check. Checkmate.

On appeal, the Third Circuit reversed and remanded the claims to the state court.¹¹⁵ The court cited *Travelers* as requiring the court to look at the text of ERISA's preemption clause to decide whether deter-

106. 57 F.3d 350 (3rd Cir. 1995).

107. *See id.* (stating that an HMO may be held liable for malpractice under an ostensible agency theory where a patient looks to the HMO for care and the HMO's conduct leads the patient to reasonably believe that they are being treated by an HMO employee).

108. *See id.* at 352.

109. *See Visconti v. U.S. Health Care*, 57 F.3d 350 (3rd Cir. 1995).

110. *See id.* at 353. The plaintiffs claimed that the HMO had held out the negligent doctor as competent and qualified.

111. *See id.*

112. *U.S. Healthcare, Inc., Germantown Hospital & Medical Center, William W. Banks, M.D., Charles R. Drew Mental Health Center, Edward B. Hosten, M.D. and U.S. Health Care. Id.* at 350.

113. *See supra* note 85.

114. *Dukes v. U.S. Health Care Sys.*, 848 F. Supp. 39, 42 (E.D. Pa. 1994); *Visconti v. U.S. Health Care*, 857 F. Supp. 1097, 1105 (E.D. Pa. 1994).

115. *See Dukes v. United Healthcare*, 57 F.3d 350, 361 (3rd Cir. 1995).

mination of the quality of a benefit received is actually a claim under § 1132(a)(1)(B)¹¹⁶ to "recover benefits due . . . under the terms of the plan."¹¹⁷ It also cited *Travelers* as requiring it to move on, if need be, to the structure and purpose of ERISA to make the above distinction.¹¹⁸ The court found nothing to support the defendant's interpretation of ERISA's preemption provision as defining malpractice actions as suits "to recover benefits."¹¹⁹ In addition, the court found that because a malpractice claim is not so completely a creature of federal law, that removal jurisdiction was improper.¹²⁰

IV. CONCLUSION

The *Dukes* court used the *Travelers* decision to find a way to get these "traditionally" state claims back into state court. *Dukes* has two implications for plaintiffs attempting to hold health care plans liable for malpractice, whether through vicarious liability for the negligence of one of its employees, or through direct negligence for the selection, retention and supervision of its personnel. First, plaintiffs' attorneys can now cite *Travelers* as allowing malpractice claims in an area that Congress did not want ERISA to preempt.¹²¹ Second, the attorney should draft the complaint in such a way as to clarify that the defendant has violated the national standard of care in making their decisions, whether for selection, retention or supervision of personnel.¹²² Most importantly, attorneys should cite the *Travelers* decision for the proposition that phy-

116. 29 U.S.C. § 1132(a)(1)(B) (1994): "A civil action may be brought . . . [by a participant or beneficiary] to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan or to clarify his rights to future benefits." This distinction may seem irrelevant because ERISA provides for concurrent jurisdiction for claims for benefits under § 1132(a)(1)(B), but this distinction is crucial. See 29 U.S.C. § 1132(e).

117. *Dukes*, 57 F.3d at 357.

118. *Id.*

119. *Id.* (citing *Travelers*' recognition that quality standards and regulations will indirectly affect the sorts of benefits that an ERISA plan may be able to afford, but that they have traditionally been left to the states).

120. See *id.* at 355. The court found that the defendants had not met their burden of establishing that removal jurisdiction was proper. "That the Supreme Court has recognized a limited exception to the well-pleaded complaint rule for state law claims which fit within the scope of § 502 by no means implies that all claims pre-empted by ERISA are subject to removal." *Id.*

121. If the claims are carefully drafted so as not to implicate any attempt at "recovering benefits," then the federal court may not find that the exception to the well-pleaded complaint rule has been met, and therefore, the claim will be returned to state court. See *Dukes*, 57 F.3d at 356-57. Depending on the district that they are in, plaintiffs can cite to *Dukes* as either binding or persuasive authority.

122. See, e.g., *Merle Jackson v. Barry Roseman, D.M.D.*, 878 F. Supp. 820 (D. Md. 1995) (ordering remand of medical malpractice claim against ERISA HMO doctor); *Lawrence Paper Co. V. Gomez*, 897 P.2d 134, 143 (Kan. 1995) (holding that state law claims were not "claims to recover benefits" and therefore were not preempted).

sicians and nurses performing prospective utilization review decisions are not the intended beneficiaries of ERISA preemption protection. Doctors and nurses should not make cost-containment decisions, without being held accountable.¹²³ ERISA was enacted to protect employees and to ensure that employers were encouraged to offer employee benefits. More often than not, employers hire third party payors to perform administration of their plans.¹²⁴ Accordingly, more and more prospective utilization review decisions are being made with no method of ensuring accountability.¹²⁵

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123. See Pittman, *supra* note 2.

124. See Zamora, *supra* note 2; see also Randall, *supra* note 2.

125. With the limited exception for HMO's that are of the staff model who deliver health care services directly. See, e.g., *Boyd v. Albert Einstein Med. Ctr.*, 547 A.2d 1229 (Pa. Super. Ct. 1988).